

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02AL0290	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/03/2013
NAME OF PROVIDER OR SUPPLIER SUNRISE SENIOR LIVING AT SEVERNA PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 41 WEST MCKINSEY ROAD SEVERNA PARK, MD 21146		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	<p>Initial Comments</p> <p>On September 3, 2013 an unannounced complaint investigation was made to the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14. Survey activities included a review of resident records, staffing records, facility documents and an interview with the Executive Director.</p> <p>The facility's census at the time of the survey was 87 residents.</p> <p>Based on survey findings, in relation only to complaint # MD00076834/ MD00078303/ MD00077909, the facility was found to be in compliance with COMAR 10.07.14, the regulations governing assisted living programs.</p>	E 000		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE